

# A Framework for the Diagnosis and Treatment of Phobic Dental Patients

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A phobia is defined as an irrational or excessive fear of an object or situation. Dental phobia can be an extremely debilitating fear, but is often a learned reflex response based on traumatic experiences. The fear response is a natural human neuroendocrine phenomena that has a strong evolutionary basis. In essence, we are all wired for this response. We can all express this wiring if we have been imprinted with the right stimulus.

Dental phobia often has its roots in traumatic experiences, but predisposing conditions can shape its expression. Conditions predisposing to dental fear include difficulty with incomplete local anesthesia, panic issues, or sensitive gag reflex. Patients with dementia have a diminished cognitive ability to cope with routine dental care; as do patients with Sensory Processing Disorder (SPD), who may have great difficulty assimilating the myriads sights, sounds, smells, and tastes common to dental environments. Studies suggest that as many as one in six children may manifest aspects of SPD, and SPD is ubiquitous for autistic patients (1).

A thorough history will help formulate a therapeutic approach. Anxiety issues are generally best treated with benzodiazepine anxiolytics such as triazolam, midazolam, lorazepam, or alprazolam. Pain is generally treated with analgesics such as NSAIDs, opiates, acetaminophen, nitrous oxide, or alpha agonists like tizanidine. Anxiolytics and analgesics are often synergistic. Incidences of respiratory depression increase dramatically when opiates are added to a sedation cocktail. The synergistic effect can be used therapeutically, lowering dosages to avoid side effects like nausea, respiratory depression or prolonged somnolence (2). Often, issues which did not originally have an anxiety component, will compound with apprehension as a learned phenomena, with repeated painful appointments or struggles controlling the gag response. Elderly patients with dementia can respond extremely well to very small doses of anxiolytics, mostly avoiding the need for deeper sedation. Deep sedation or general anesthesia should be avoided where ever possible to avoid the potential for permanent cognitive decline.

Patients will often use verbiage that is diagnostic for panic or PTSD, reflecting the fight or flight response. Patients share various incidents—they may relate having to run out of a medical or dental situation in the past; or express the fight component by saying they bit or kicked a health care provider. Establishing the etiology of the dental fear or source of avoidance of care, points to therapy (3). Oral sedation can raise the threshold for a panic attack, pain perception, or setting off the gag reflex. IV sedation allows for titration of short acting anxiolytics, propofol, or opiates. Intravenous sedation is more appropriate for deeper levels of sedation because it provides a lifeline for rapid administration of emergency medications, provides for hydration, and more rapid emergence from anesthesia. General anesthesia is indicated where the airway needs to be secured for reasons relating to the surgical procedure, or medically compromised patients. Practitioners need to plan the level of anesthesia based on all these factors. The skill level, licensing, and training of the practitioner should determine the level of sedation offered to the patient, not the route of administration.

There are additional treatment planning considerations for patients requiring sedation. Often, dentally anxious patients are absent care for many years, even decades. Patients often suffer from a lack of dental education, effecting the cariogenic nature of their diet, and lack of effective home care. Patients may present with disfiguring dentitions as a result of long term avoidance of care. Treatment planning is phased to reflect medical, dental health priorities, and address the immediate needs of relieving pain and infection.

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Patients may have a life-long pattern of dental absence, and can easily be overwhelmed with a comprehensive treatment plan. Patients often have a deep sense of shame and embarrassment about their oral condition that may also have its roots in a history of trauma, abuse, depression, and neglect. It is extremely important to be positive, and not personally critical of the patient's situation. Many dental

phobics have co-morbid emotional issues raising challenges to meeting commitments to appointments, or financial arrangements. They are acutely aware of their needs, but often feel it's impossible for them to get dental care because of their overwhelming fear. It takes time to learn the needs of these patients, and formulate a plan of care that they can accomplish. Giving the patient short term attainable goals is often a more pragmatic and realistic approach. Committing the patient to a treatment plan that may not be completed as planned can be a strong negative for patients and providers. Once a patient has completed a course of care where they are able to have basic dentistry, and achieve a clean healthy mouth; additional, more sophisticated procedures can be planned. All this should be communicated to the patient to determine their goals.

A post operative pain management strategy that is sensitive to the patient's needs is an essential component of overall care. Patients with a history of emotional trauma have an increased incidence of anxiety, depression, and chronic pain later in life. Thinking ahead can reduce unnecessary suffering and improve their experience. Part of our mental routine at the conclusion of a treatment appointment should be to discuss the pain management plan. Having the patient take naproxen (peripherally acting at the site of injury), and acetaminophen (centrally acting) together at the end of an appointment, before leaving the operatory, insures some analgesia before the local anesthetic is gone. Non-narcotic analgesics can be prescribed so that the patient has round the clock coverage for the first twenty-four

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hours. Naproxen, and NSAIDS in general, have an opiate sparing effect so that requirements for hydrocodone or oxycodone will be reduced. Naproxen is advantageous over ibuprofen for its longer duration of action. Patients are instructed to use naproxen and acetaminophen before reaching for the opiate analgesic. Opiates are used for breakthrough pain, but may be given in reduced dosages if there is a baseline of analgesics already on board. Reducing opiate dosages will reduce the incidence of nausea, and lethargy associated with these medicines. I generally prescribe the 5 mg hydrocodone tablet, and instruct patients to start

with half a pill, and titrate themselves up from there.

A team approach is essential for efficient operation of a dental practice. It is even more so with an anxious population that may frequently change appointments, have frequent emergencies, and require substantial emotional support. Additionally, if sedative medications are employed in the practice, safety issues become paramount. Patients with obstructive sleep apnea are particularly sensitive to sedatives intra-operatively. Due caution should be employed especially for the combination of oral and intravenous sedatives and post operative opiates. A responsible adult should accompany the patient home, and remain with the patient. Patients at risk for falls must be similarly watched. Elderly patients, those with heart disease, hypertension, or diabetes are typically given morning appointments so that NPO requirements for sedation do not result in dehydration. While patients are instructed not to have anything to eat or drink prior to the appointment, they are encouraged to have water up to two hours pre-op, as adequate hydration helps people recover faster from any anesthesia, and feel more like themselves.

It is not uncommon for patients to express that this process of restoring their oral health, is life changing for them; allowing them to develop personal relationships, careers, and improved self esteem. This feedback from patients is professionally satisfying, and makes all the effort worthwhile. Often, people ask me what techniques I use to treat my patients. The essence is to listen to the patient, determine their concerns and design a plan of care that addresses their needs. ■

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